"This is Your Life"

JOHN ROBERTS PHILLIPS, M. D.

5806 Bayou Bend :-: Houston, Texas

Volume III Medical Works

BOOK XII

Compiled as a Gift at Christmas, 1956
By Your Wife "OLD FAITHFUL"
REBECCA HALL PHILLIPS, R. N.

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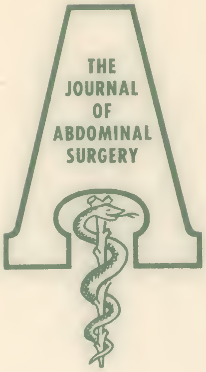

THE
JOURNAL
OF
ABDOMINAL
SURGERY

Malignant Tumors of the Stomach

JOHN ROBERTS PHILLIPS,* M.D.

WHEN WE REFER TO MALIGNANT TUMORS OF the stomach, we are talking primarily about carcinoma of the stomach, for 95% of all malignant tumors of the stomach are adenocarcinoma. It occurs twice as frequently in males as in females. Lymphosarcoma makes up about 3-4%. Leiomyosarcoma makes up about 1% of the total. Only an occasional carcinoid of the stomach has been reported — 20 in the entire literature.

The incidence of cancer of the stomach is decreasing. This is as striking as the marked increase of cancer of the lung. In large centers the decrease in the past 10 to 15 years has been as much as 25 to 50%. This decrease is probably due to a number of factors, such as: 1) Nutritional factors. 2) Infectious causes, e.g. a pandemic of viral or bacterial origin which has not recurred. 3) Lessened exposure to unknown chemical carcinogens. 4) Reduction in pre-malignant lesions such as pernicious anemia and chronic gastritis. 5) Changing social factors, other than dietary.

There has been a lot of pessimism about cancer of the stomach because we see so many late cases in which nothing can be done, and because there is a low curability rate. The reason for this is that it runs such a long silent phase before any symptoms are apparent. Often the symptoms at the beginning are only minor such as gaseous eructation, a fullness or a mild aching distress. As a matter of fact, these symptoms may be all that are present in a far advanced case. Weight loss is a very significant finding. We have all seen cases picked up on x-ray examination of the stomach in which there were practically no symptoms. Patients have a tendency to procrastinate and delay examination, often taking drug store remedies for a period of time which further delays the situation. Then, at the time of presentation of himself to the doctor, the symptoms being so minor, the doctor will give a course of medication without having a fluoroscopy made of the stomach. On medication the patient feels better, and a further delay takes place.

We lean heavily on the x-ray for the anatomical location of the lesion and also for the diagnosis of malignancy or benignancy. There is a diagnostic x-ray capability of about 90 to 95%. Clinical judgment must be used as to whether to accept a negative x-ray report. If a lesion is suspected, there should be no hesitancy in having a repeat examination. The roentgenologist may have difficulty in differentiating between a benign and malignant lesion; the accuracy probably won't be better than 70% and 10 to 15% of gastric malignancies are thought to be benign on first examination — a change of opinion may occur on subsequent examination.

When a known lesion is present, gastroscopy is not infallible. Even if a biopsy is made from an ulcer crater, the ulcer may be part malignant and part benign. Often, by the time the patient has developed symptoms to the point where it is a question of having a gastroscopy, the patient should be operated upon anyway. Gastric cell washings have been tried, but this probably will never be a very practical way of screening a large mass of people. In other words, if the lesion is suspicious enough to have these diagnostic tests, it is safer to remove it for microscopic study, doing a curative procedure — usually a partial gastrectomy.

There has been a lot of discussion as to the problem of gastric ulcer and how often it becomes malignant. In the recorded series, the incidence of malignancy in a gastric ulcer runs from 10 to 20%. The location of the ulcer and the duration of symptoms will guide one as to the treatment. If medical treatment is undertaken, it should not be engaged in for more than three to four weeks, and preferably the patient should be in the hos-

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*Houston, Texas

pital. Under treatment the symptoms should disappear, and the ulcer should disappear on fluoroscopy. If it has not cleared, then surgery should be promptly advised. Occasionally in a malignant ulcer, the niche may disappear. This is particularly in reference to ulcers on the lesser curvature of the stomach. Ulcers in the antrum are more dangerous than those on the lesser curvature. The course of the gastric ulcer is so unpredictable and the results following surgery are so good that the proper method of treating them is by surgery. If there is a case of severe chronic gastritis in association with the ulcer, one can almost predict that the ulcer will not heal and remain healed, so early surgery in that group should be advised.

If the ulcer is malignant, the process may be confined to the stomach itself, and the hope of cure will be much greater. In a study of a series of patients with cancer localized in the stomach without any evidence of distant spread, the curability rate was high.

Comfort, et.al., have made a very careful study of small gastric cancer and found the prognosis depends on the grade, the presence or absence of metastasis, and even on the acidity readings. The prognosis is poorest in the cases of achlorhydria. "In short, the small gastric cancer with features suggestive of benign gastric ulcer; ulcer dyspepsia of several years duration, active secretory gastric activity, and roentgenologic appearance indistinguishable from benign ulcer, has the best prognosis after gastric resection. Unfortunately this is the gastric cancer most frequently treated medically, in the belief that it is a benign ulcer." According to Walters, 28% of the patients seen with gastric cancers at the Mayo Clinic had ulcer-like symptoms.

A gastric polyp is another precancerous lesion. These should all be excised and immediate microscopic examination made. Should there be malignancy, one should go ahead with a radical gastric resection. Only occasionally will polyps be so numerous that a total gastrectomy will be necessary to eradicate the condition.

It is extremely difficult to screen everyone for the possibility of gastric cancer. However, it is well for every patient at one time during his complete annual physical examination to have a gastric analysis made. If achlorhydria is found, further studies should be made to see if this is a case of early pernicious anemia. All patients with achlorhydria should have a fluoroscopy of the stomach once a year. In patients with pernicious anemia with a chronic gastritis, one should be particularly on the lookout because of the increased incidence of malignancy. The incidence of carcinoma of the stomach is four times higher in individuals with achlorhydria.

All patients with carcinoma of the stomach are subjected to abdominal exploration provided there is no evidence of distant irremovable spread such as supraclavicular metastasis; metastasis to the umbilicus, or evidence of malignancy on the rectal shelf. Even excluding these cases at exploration about one-half of the patients will be inoperable because of the extent of the disease in the abdomen. One hopes to remove not only the primary lesion, but also the nodes where it may spread. Although the extent of the operations have been increased, when the process is extensive, the curability rate declines rapidly. In some cases nothing more than a palliative procedure can be carried out. It is advisable to remove the lesion for palliation if it can safely be done to get rid of the bleeding, absorption, and the obstruction. It is a much better procedure than a gastroenterostomy. A gastroenterostomy does not offer too much in the palliation of cancer of the stomach.

The type of operation that is used and which will be applicable to one-half of the cases is a radical distal resection which consists of removal of about 85% of the stomach, all of the greater omentum, the lesser omentum, the gastro-colic omentum, the nodes around the head of the pancreas and the common duct; and the removal of the spleen with the nodes in the hilum and along the upper border of the pancreas. The tail and body of the pancreas usually are not removed unless there should be an indication. About 10 to 15% of the cases will require a total gastrectomy, because of the extent of the process. If the carcinoma involves the lower end of the esophagus, a distal resection of the esophagus and the upper portion of the stomach may be indicated, with anastomosis of the esophagus to the distal stomach accompanied by a pyloroplasty because of the sacrifice of the vagus nerves.

Cancer of the stomach may bleed very severely, although usually not as severely as cases of ulcer. However, in a study of 135 cases in the Mayo series dying of fatal hemorrhage, it was found that cancer of the stomach with severe hemorrhage was the cause of death in 20 cases. Peptic ulceration and esophageal varices held first and second place.

The cause of an obstruction at the pyloris may be due to a stenosing duodenal ulcer. Pre-operative diagnosis may be impossible and at the operating table it may be difficult to determine if the lesion is gastric or duodenal until it is removed.

A carcinomatous ulcer may acutely perforate. If the patient is seen early and is in good condition, a partial gastrectomy should be done. All perforated gastric ulcers where partial gastrectomy is not applicable should be completely excised so that the entire lesion can be studied microscopically. Should malignancy be found, a re-operation can be done later with radical partial gastrectomy. Chronic perforated ulcers on the posterior wall of the stomach must be removed for microscopic study. The crater may be in the pancreas. If malignant, the resection of adjoining organs will be necessary also.

We see patients with a palpable tumor in the stomach which has been there for a considerable length of time. These patients may have a better prognosis than those with a small lesion. This indicates the carcinoma is a low grade type, and the prognosis might be very good in spite of the fact there may be some involvement by continuity of the adjoining organs such as the colon. One is justified in doing an extensive resection in such an individual. One of my cases is now living seven years after a combined right colon, transverse colon and radical gastric resection for carcinoma of the greater curvature which involved the transverse colon. Oftentimes a small lesion in the stomach is a very malignant, explosive, vicious type of lesion, and may show very extensive metastasis. All in all, however, in a large analysis of small gastric cancer cases, the prognosis is best.

The curability in the collected series runs about 10% in the patients who have had a curative resection, and occasionally a patient who had a palliative resection will surve for five years due to the slow growing nature of the tumor, and the patient is by self-resistance able to control his disease well. The reported series from Hawaii have shown a 14% survival for five years. The risk for radical resection in all cases runs about 10% where a radical distal gastric resection is carried out. The risk of resection in the small cancer under 2.5 cm. runs about the same as for resection for ulcer. The risk of total gastrectomy is 15 to 20%, and the risk of proximal resection of the esophago-gastric junction runs about 25%.

There have been no cases reported of a five-year cure in which the proximal resection has been done. The risk is not due to the operative procedure alone, but to associated conditions such as cardiovascular disease or renal disease, etc. Autopsies done on patients dying after gastric resection have shown one-half of the hospital deaths following surgery are due to conditions entirely outside the abdomen.

We are always looking and thinking of a way which will enable us to get these cases early, so we may increase the five-year survival rate. We depend heavily on the roentgenologist. René A. Gulman has been talking about radiologists picking up certain changes in the stomach which are highly suspicious and warrant resection. He has advised exploration and resection, even though the surgeon may not be able to palpate the lesion, and has been rewarded by finding early carcinoma. By such careful teamwork, one may improve one's results as far as curability is concerned.

Radioactive phosphorus (P-32) is being used to detect carcinoma of the stomach, and they have had encouraging results. It will be a great step forward when a screening test can be carried out with the same degree of accuracy as a Papanicolaou smear test, and when the surgeon may get the case early before he can palpate or see a lesion.

I am confident we will develop an accurate method of screening people and finding carcinoma early when the lesion is confined to the stomach. Then, the curability rate will be high, probably about 80%. Since cancer of the stomach is decreasing, it gives us a clue for careful study of changes that have been taking place to find the preventive factors.

MEDICAL ARTS BUILDING AND HOSPITAL
CAROLINE AND WALKER STREETS
HOUSTON 2, TEXAS
CAPITOL 8-8181

JOSEPH A. CONNER
ADMINISTRATOR

BOB STEVENSON
ASSOCIATE ADMINISTRATOR

Dear Doctor:

Recently a magnificent brochure has been prepared illustrating the Medical Arts Building as it appears today. It is a truly handsome publication.

Obviously this has been developed for promotional use. However, we know that you will want copies to show to your family, friends, patients, and associates.

Enclosed are two copies. We feel that you will be as pleased as we are with this beautiful booklet.

Sincerely,

Bob Stevenson
Bob Stevenson

Medical Arts Building

& Hospital


PARK

Meticulous care has been taken to make the Medical Arts Building a handsome, efficiently managed location for medical offices. The building staff is trained to give prompt attention and service to the needs of tenants. Professional assistance in the design, decoration and equipping of offices is available without cost.

There are some 100 doctors and 40 dentists officed in the Medical Arts Building. Pictured are reception areas, physician's consultation rooms and a dental operatory in the building.

The hospital facilities within th

The hospital occupies the second,

One of the three major operating rooms; the hospital also has one room for minor and dental surgery, one urological surgery room, and a post-recovery room.

e building allow physician tenants to be just minutes from

their hospital patients during office hours.

third, fourth and fifth floors. It has 275 doctors on its staff.

Patient rooms are colorful and commodious. The size of the nursing staff allows personal nursing care of approximately 4.5 hours per day to each patient.

The hospital kitchen offers well balanced, palatable meals for patients. All meals are carefully prepared under the supervision of a graduate registered dietitian.

The Medical Arts Building contains a modern pharmacy, gift shop, and a doctors' lounge for the use of professional tenants. It also has a modern restaurant and grill.

HOUSTON'S MEDICAL ARTS BUILDING, in the heart of downtown Houston provides leading doctors and dentists with modern, comfortable offices.

To maintain its high quality of service to Houston's medical profession, the building's owners, who purchased and assumed management of the 16-story structure in 1961, have spent one-half million dollars in its modernization program.

The program included exterior changes resulting in one of the most attractive facades in the city of Houston; the installation of automatic doors leading into the building; an entire overhaul of the air conditioning and mechanical system throughout the building; the construction of modern offices in accordance with present day standards, and expansion of hospital facilities.

The growth of downtown Houston has made the Medical Arts Building and Hospital an important adjunct and has proven invaluable to this growth. It is easily accessible to such newly constructed buildings as the Humble, Tennessee, First Federal, First City National Bank, Bank of Southwest, as well as the newly constructed hotels such as the Sheraton-Lincoln, Hotel America and Continental Houston. Mass transportation from all areas of the city lead into the heart of downtown Houston. Ample parking space is available at all times of the day and night.

The Medical Arts Hospital was established in 1958 with 93 beds. Due to demand, an additional 47 beds were created with the opening of another hospital floor. The hospital now occupies the 2nd, 3rd, 4th and 5th floors of the building. Scientific equipment and assistance necessary for today's surgery and treatment of patients is provided in this modern expertly managed facility.

Gleaming corridors — bright, cheerful rooms — modern operating rooms and equipment — excellent nursing staff. The Medical Arts Hospital, fully accredited by the Joint Commission on Accreditation of Hospitals, is staffed, equipped, and administered to meet the needs of both physicians and patients.

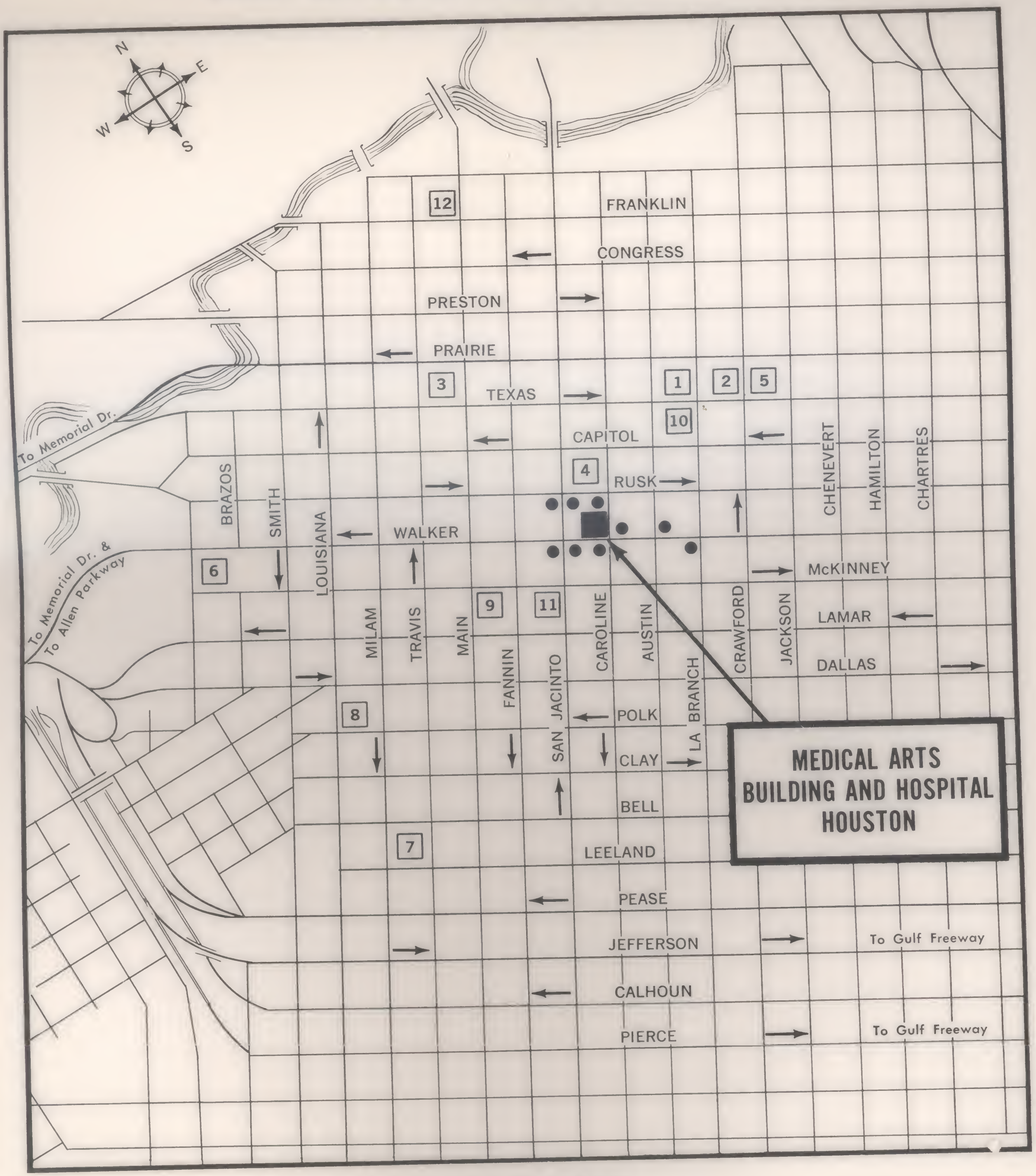
Facilities such as the pharmacy, grill, and parking garage add to the conveniences enjoyed by building users.

It is the desire of the ownership that the Medical Arts Building remain a permanent professional building catering only to the most reputable physicians and dentists who are members in good standing of the Harris County Medical or Dental Societies.

As you will note from the map, we are three blocks from the heart of the city. There are excellent parking facilities readily available at all hours of the day and night. A nine-story parking garage is immediately across the street and a five-story parking garage adjoins the building. There is ample open lot parking adjacent to the Medical Arts Building and immediately across Caroline Street. All major transportation lines come within one to three blocks of the Medical Arts Building.

We invite inquiries for office space. For information, call or write Medical Arts Building, Houston, Texas

MAP OF DOWNTOWN HOUSTON



KEY TO MAP

1. WM. PENN HOTEL
2. BEN MILAM HOTEL
3. RICE HOTEL
4. POST OFFICE ANNEX
5. RAILROAD STATION
6. CITY HALL
7. HUMBLE BLDG.
8. SHERATON-LINCOLN HOTEL
9. FIRST CITY NATL. BK.
10. GREYHOUND BUS ST.
11. CONTINENTAL BUS CENTER
12. CONTINENTAL HOUSTON

PARKING GARAGE AND LOTS ●

1215 WALKER AVE., HOUSTON, TEXAS

Dear Doctor,

You and your guests are cordially invited to inspect and enjoy the 'Doctors Retreat' at Medical Arts Drug open house, Friday, December 28, 1962 from 3:30 P. M. to 6:00 P. M.

Ray Bratton

Ray Bratton

CLINICAL CONGRESS OF ABDOMINAL SURGEONS
NEW YORK CITY
APRIL 28 - MAY 3, 1963

JOHN R. PHILLIPS, MD.

HOUSTON, TEXAS

COMMITTEE

AMERICAN MEDICAL ASSOCIATION

June 18, 1963

JOHN R PHILLIPS MD
acute appendicitis
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AMERICAN COLLEGE OF GASTROENTEROLOGY

Mrs. John Phillips
Texas

AUXILIARY MEMBER

HOSPITALITY

THE HOUSTON CHRONICLE

AUXILIARY TREASURER —Mrs. John Roberts Phillips was elected treasurer of the American College of Gastroenterology Auxiliary at a recent meeting in Philadelphia.

THE HOUSTON
SUNDAY, OCTO

NEW OFFICER — *Mrs John Roberts Phillips has been elected treasurer of the Women's Auxiliary of the American College of Gastroenterology. She was installed at a recent meeting in Philadelphia.*

CHRONICLE

NATIONAL OFFICER— Mrs. John Roberts Phillips was elected vice-president of the Woman's Auxiliary of the American College of Gastroenterology, at its recent national meeting in Chicago.

OFFICER — Houston's Mrs. John Roberts Phillips was elected vice-president of the Women's Auxiliary of the American College of Gastroenterology at its recent meeting in Chicago.

The Houston Press

WEDNESDAY, NOV. 27, 1963

* * *

Mrs. John Roberts Phillips, wife of the Houston physician, was named president-elect of the Women's Auxiliary to the American College of Gastroenterology at a meeting in the Shoreham Hotel in Washington. The former treasurer and vice-president will take office in 1964.

* * *

Society Today

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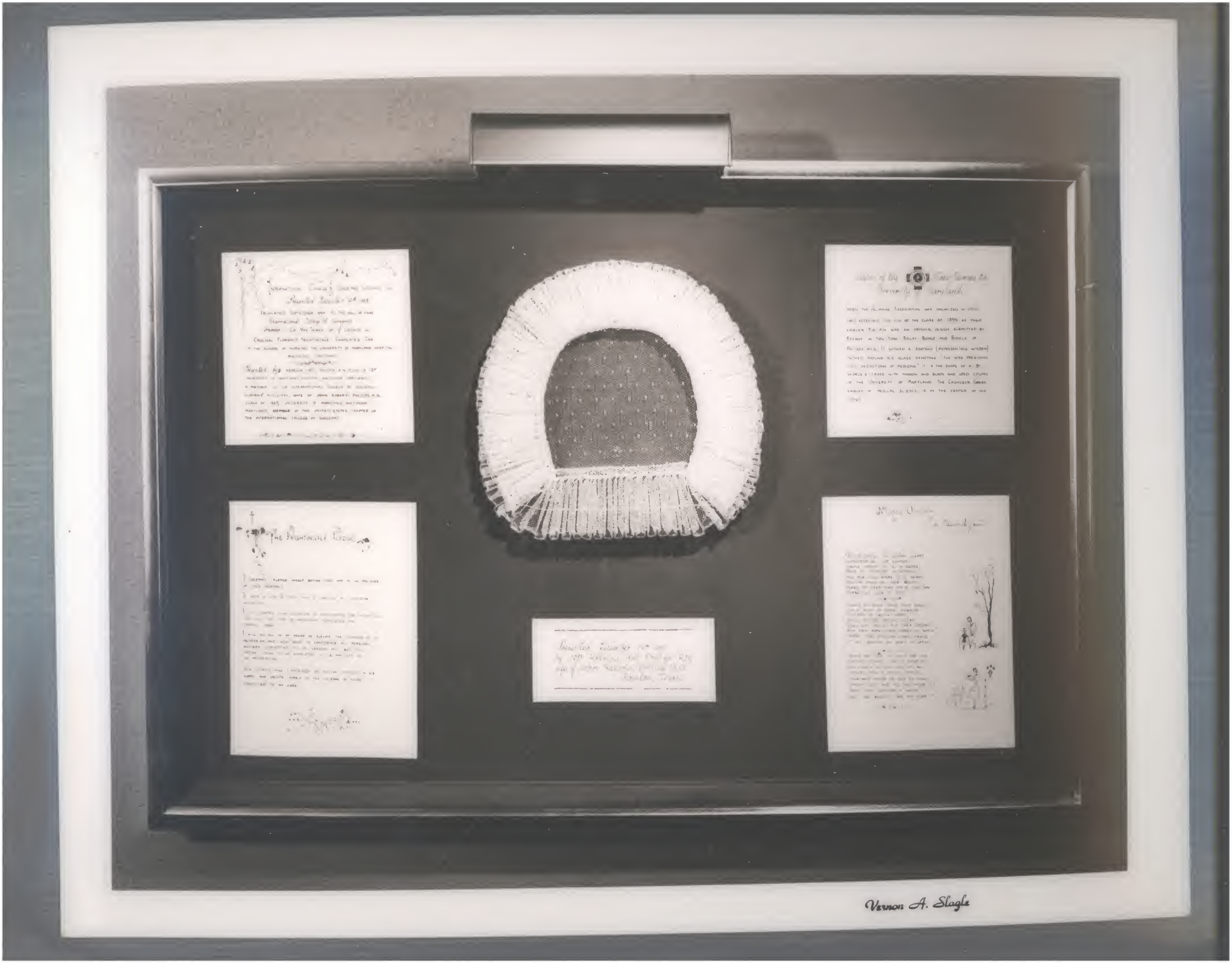

Vernon A. Slagle

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MAYOVOX

Vol. 15, No. 5 Published for the Men and Women of the Mayo Clinic January 4, 1964

Clinic and Rochester Will Join In Noting Mayo Centennial Year

"The year 1964 has been designated the Mayo Centennial Year . . . (and) is being planned to commemorate the births of Dr. William James Mayo and Dr. Charles Horace Mayo and to celebrate the fiftieth anniversary of the establishment of the Mayo Foundation.

" . . . having re-examined the past through review of the lives, contributions, philosophies and ideals of Dr. W. J. Mayo and Dr. C. H. Mayo, the events of the Mayo Centennial Year should provide the occasion and the inspiration for projection of patterns for future progress in improving medical care, extending and improving graduate medical education and broadening productive research opportunities."

From Centennial Committee minutes, March 1, 1961

The Mayo Centennial Year, born of the wish of the present Clinic generation to honor the founders, developed in three years of detailed preparation, has begun.

On January 2 a Centennial exhibit, a biography in pictures of the Mayo brothers, was officially opened. It will remain at the north entrance of Mayo Building's main floor throughout the year.

The Centennial Committee, chiefly responsible for planning, is pictured here. Its chairman, Dr. C. S. MacCarty, in reporting to the staff at the annual meeting in November, noted that ". . . it was necessary to call upon the services of certain permanent committees of the Mayo Clinic and to create new subcommittees . . ." in developing and carrying out plans. And, "because many organizations and institutions in Rochester wished to participate. the Chamber of Commerce established a Mayo Centennial Committee."

Together these committees have evolved plans which Dr. MacCarty outlined briefly in his report and which will be described in more detail as the dates of the events approach. They include . . .

. . . . the Centennial exhibit already mentioned.

. . . . design of a Centennial seal, now in use.

The Mayo Centennial Committee. Seated, left to right: Dr. J. R. Eckman, Dr. C. S. MacCarty (chairman), Mr. E. H. Schlitgus (secretary) and Dr. Victor Johnson. Standing, left to right: Dr. H. B. Burchell, Dr. R. G. Sprague, Dr. C. F. Code, Dr. G. A. Hallenbeck and Dr. E. S. Judd.

Centennial To Honor Mayo Brothers


Doctor Will

Your chairman, in his kind remarks, has forgotten the most important factor in what I may have accomplished: that is, my association with my brother . . . . Our association has been unique not only in the love and confidence we have for each other but in having made an opportunity for two men to work as one and to share equally such rewards as have come . . . .

—W. J. Mayo

• • • •

Often when medicine has seemed to have reached its acme, somebody, somewhere, has opened a new door, not a door to a room the contents of which can be seen, examined and catalogued in a relatively short time, but a door to a new corridor out of which open other doors to other corridors in an endless perspective of opportunity.

—C. H. Mayo

• • • •

To hold an honest view of a situation is one thing; to believe that anyone who holds a different view must be wrong, and to attribute to him evil motives, is quite another . . . Bigotry, especially when based on ignorance, has led to most of the great disasters that humanity has suffered . . .

—W. J. Mayo

What pleasure and comfort I have had from my hours with younger men. They still have their imagination, their vision, the future is bright before them . . . they give me of their dreams and I give them of my experience and I get the better of the exchange.

—W. J. Mayo


Doctor Charlie


Dr. Will was many things: physician, educator, administrator. But it was in surgery that he found greatest satisfaction.


Dr. Charlie was not only a truly great surgeon; he was also a truly superb surgical teacher.

Dr. Will: "a weekend at the river."

Let the aging man do something new, vivid and interesting, every day. Let him learn something new, meet new people, engage in some new activity, think a new thought, feel a new interest, discard an old prejudice, find thrill in a new experience, rejoice in some new perception of beauty in nature or art, be touched by some new sympathy, play a new game, acquire a new art or skill. These are the things of youth. He who at any age still does them is young. He who at any age, falls into a rut, thinks the old thoughts, rests on the old knowledge and experience, is set in the old habits, whose interests are stereotyped and his emotions stale — he is old.

—C. H. Mayo

In honors, too, it was "My brother and I."

There are many recompenses in a seventieth birthday. I look through a half opened door into the future, full of interest, intriguing beyond my power to describe, but with a full understanding that it is for each generation to solve its own problems and that no man has the wisdom to guide or control the next generation. It is a comfortable feeling, to be interested in what is to happen, but to be in no way responsible to bring it about.

—W. J. Mayo

In the quieter, later years, still together — Dr. and Mrs. W. J. Mayo at left, Dr. and Mrs. C. H. Mayo at right.

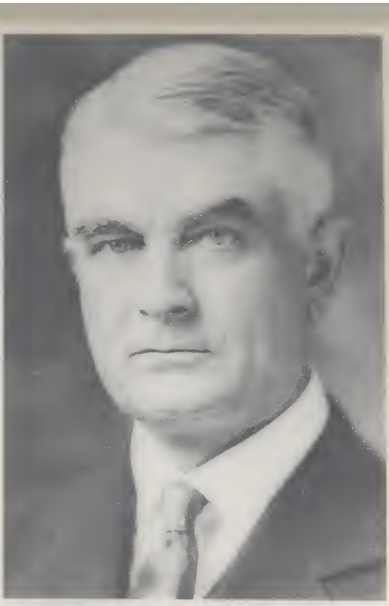
. . . I want to say a word in appreciation of our father, W. W. Mayo, whose genius, knowledge, and rare judgment made the great opportunity possible for Will and me. Out of gratitude for this opportunity, we believe we should do everything in our power to pass on to others the opportunity to obtain the medical instruction that we had acquired with so much difficulty and hard work. Our father's training made us appreciate most fully that education and not money is the only gift worth while and permanent.

—C. H. Mayo

I'm not exactly a farmer; I'm an agriculturist; the difference is that whereas the farm gives the farmer a living, the agriculturist gives the farm a living.

—C. H. Mayo

Charles Horace Mayo, M.D.



William James Mayo, M.D.

For New Clinic Generation Here Are Mayo Brothers

Charles Horace Mayo, M.D. — Dr. Charlie — was born in Rochester, Minn., on July 19, 1865.

Like his elder brother, he worked from the time that he was a small child with his frontier-physician father in caring for the sick and injured.

He received the M.D. from Northwestern University in 1888, returned to join the thriving family practice which, a year later, began assuming new dimensions with the opening of St. Marys Hospital.

A man of varied talents, Dr. Charlie was first and pre-eminently a surgeon: with fraternal pride, his brother — himself famed in the field — was to say in later years that "Charlie soon had me driven to cover by being a better surgeon, and I began to specialize in abdominal work and in operations on the ureters and kidneys." It has been said that Dr. Charlie's natural mechanical versatility helped him to conceive and perfect technics best suited to solve the many different surgical problems which he attacked with such great success.

Dr. Charlie found a special satisfaction in teaching. Both in the earlier years and later under Mayo Foundation for Medical Education and Research, he earned fame as an educator and the high regard of the hundreds of young physicians who worked with him in the operating room.

A wealth of professional and related honors came to Dr. Charlie.

Among organizations in which he served as president were the Western Surgical Association, Society of Clinical Surgery, Clinical Congress of Surgeons of North America, American Medical Association, American College of Surgeons, American Surgical Association and Inter-State Postgraduate Medical Association.

During World War II, he contributed notably to medical phases of the U. S. Army; in 1917-18-19 he alternated with his brother as chief consultant for all surgical services for the Medical Department of the Army in the Surgeon General's Office. He held memberships in more than 50 professiona organizations in this and other countries — and, locally, he served as city health officer for 25 year and as school board member fo several years.

Yet despite his many posts and honors, Dr. Charlie, like his brother, in the best and truest sense belongs to medical history for hi part as co-founder of the institutions that bear his name.

William James Mayo, M.D. — Doctor Will — was born in LeSueur, Minn., on June 29, 1861.

Strongly encouraged by his father, an able and dynamic frontier physician-surgeon, Dr. Will was dedicated to a career in medicine from early childhood.

He received the M.D. from the University of Michigan in 1883. With his younger brother — throughout his life his closest friend, confidante and professional colleague — Dr. Will joined his father in practice in Rochester. Increasingly, the sons took over the practice which, after 1889, began to expand in size and scope with the opening of St. Marys Hospital.

In 1892, another physician was invited to join the Mayos. Continually increasing patient demand led to further addition of physicians and surgeons to the practice which, shortly after the turn of the century, came more and more to be known as "The Mayo Clinic." From this beginning the Mayos shaped and defined the principle of the integrated private group practice of medicine which became fundamental to care of the sick here.

Deeply concerned with the advancement of the profession which he loved, Dr. Will throughout his life continued to learn and, in his turn, to teach younger physicians. With his brother, he gave a substantial fortune to bring into being Mayo Foundation for Medical Education and Research. With his brother, he sought until he found in Mayo Association "a vehicle whereby the money received from the sick could be returned to the sick through better medical education and research." His personal contributions as a surgeon placed him among the top rank of surgeons of his day.

For his work as surgeon, educator, administrator, soldier and citizen, Dr. Will received almost countless honors from professional peers and others. For example, groups from 17 different nations — and several of the nations themselves — paid him tribute.

Professionally, he was president of the American Medical Association, Society of Clinical Surgery, American Surgical Association, American College of Surgeons, Congress of American Physicians and Surgeons, Inter-State Postgraduate Medical Association of North America.

But, it seems safe to say, his proudest memorial is the continuing progress of the Mayo institutions to which he gave so unstintingly of his wisdom, strength, talents and dedication.

. . . . a plan to recreate the office of Dr. Charles H. Mayo in space directly to the south of Dr. Will's office on third floor, Plummer Building.

. . . . two staff meetings, planned for summer, to honor the brothers.

. . . . tours of Mayo Foundation House.

. . . . a Mayo exhibit at Olmsted County Historical Museum (already on display).

. . . . an exhibit at the Rochester Art Center.

. . . . arrangements for meetings of some 36 medical societies (including the Minnesota State Medical Association) to be held in Rochester in 1964.

. . . . a concert by the Minneapolis Symphony Orchestra.

. . . . a Mayo Centennial Symposium to be held in September during the meeting of the Alumni Association.

. . . . a convocation at which citations from the Board of Regents of the University will be presented to participants in the symposium and Outstanding Achievement Awards will be presented to outstanding alumni of the Mayo Foundation.

. . . . civic events including commemorative ceremonies, unveiling of historical plaques, joint meetings of service clubs for programs of Centennial significance, Memorial Day ceremonies, participation of schools and churches, historical tours, and a Rochester Recognition Day.

The symposium, titled "Man's Adaptation to His Expanding Environment," regarded as the most significant event of the Centennial Year, was planned, reported Dr. MacCarty, as ". . . an event of international scope beyond the latitudes of medical science (which) would provide a stimulating experience and enhance the cultural aspects of our community and organization." It will be held September 17 and 18, and will be preceded on the evening of the 16th by a concert by the Minneapolis Symphony Orchestra.

Moderator of the symposium will be Dr. Laurence M. Gould, immediate past president of Carleton College. Participants will be Dr. Loren C. Eiseley, Dr. Peter B. Medawar, Dr. Rachel L. Carson, Dr. Edward Teller, Dr. Arthur Larson and Dr. C. A. Doxiadis. At a banquet and formal convocation the evening of September 17 speaker will be General Lauris Norstad.

Both the Clinic Library and the Rochester Public Library plan exhibits of some of the published works of the participants in the symposium.

A brochure describing events of the Centennial Year is to be mailed to alumni of Mayo Foundation and others. The presidents of universities of the Upper Midwest and adjacent Canadian provinces, deans of medical schools in the United States and Canada and representatives of local, state and federal governments and of national medical societies will be invited to the symposium. It is anticipated that the symposium, and the medical meetings throughout the year, may bring some 7500 persons to Rochester.

It is appropriate that unsparing effort be made in planning the events of Mayo Centennial Year, and, Dr. MacCarty told staff members, "your cooperation in making these events successful will be solicited as the occasions arise." Yet the measure of success, as the Committee is well aware, will not be in number of visitors, nor eminence of participants, nor depth of news coverage.

In the forest of detail the core purpose of Mayo Centennial Year should not be forgotten, and that is to show honor to Dr. William J. and Dr. Charles H. Mayo. To those who knew them, their images are unobscured by the twenty-five years since their passing. Others have learned to know them through that indelible imprint left on the institutions which bear their name.

It is hoped, the committee chairman has stated, "that the Centennial celebration will serve as a means for members of the staff, fellows of the Mayo Foundation and nonmedical personnel to become reacquainted with the high principles and ideals of the founders," and "that the events of the Centennial Year will provide an inspiration for projection of a pattern for further progress in medical care, medical education and productive research opportunities."